Performance, Value, Outcomes: Medicaid Managed Care

FY 2013-2014

The mission of the Michigan Association of Health Plans is to provide leadership for the promotion and advocacy of high quality, affordable, accessible health care for the citizens of Michigan.

Medicaid White Paper: FY 14

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RECOMMENDATIONS FOR FY 14 AND BEYOND

1. The State of Michigan should continue to assure actuarially sound rates as the underlying principle in support of Medicaid Managed Care. All Medicaid Policy bulletins issued by the Department after “Actuarial Soundness” federal approval should include economic analysis to demonstrate that the approved rates are not compromised by proposed changes in Medicaid Policy.

2. The State of Michigan should implement the option to expand Medicaid Eligibility to 133% of Poverty.

3. The State of Michigan should renew the Health Insurance Claims Assessment, HICA, Act by extending or repealing the current sunset (December 31, 2013)—while maintaining a rate of no more than 1%.

4. The State of Michigan should consider implementing an Integrated Long Term Care Initiative to parallel the implementation of the CMS/MDCH Initiative for Dual Eligibles that will now be limited to 4 regions of the state.

5. The State of Michigan should continue to improve and reform Medicaid eligibility by:
   a. Operationally, creating a default eligibility and enrollment for newborns to be assigned to the same Medicaid health plan as the mother at the time of birth (consistent with the terms of the Medicaid Contract).
   b. Considering the option to delink Medicaid application from other human services program applications in order to accelerate eligibility and enrollment.
   c. Implement a user-friendly system for beneficiaries and Medicaid Health Plans for determining expanded Medicaid eligibility and enrollment choices at the time of eligibility—similar to the system used for enrollment of MI CHILD.
   d. To help reduce enrollment and eligibility “churning”, Michigan should consider the feasibility of implementing either a bridge plan or basic health plan in conjunction with the Insurance Exchange.

6. The State of Michigan should continue their efforts in streamlining and coordinating the administration and oversight of Medicaid Health Plans and related contracted entities by:
   a. Merging the state administered contracts for MI CHILD and Medicaid Health Plans at the next earliest opportunity;
   b. Reduce or eliminate paper requirements in lieu of electronic documents and web-based information sites and begin using “deemed compliance” by virtue of national accreditation such as NCQA or URAC; and
   c. Changing the regulatory perspective to a “regulation by exception”—that is focused on contractors who may not be meeting standards established in the contract.
7. The State of Michigan should continue efforts to maximize all levels of non-GF Revenue (Federal, special use, local revenue, and cost avoidance) to protect Michigan’s Safety Net. This focus would continue and expand efforts for:
   a. Medicaid Health Plan Special Access and Supplemental Programs to assure outreach and coverage for Medicaid beneficiaries;
   b. Securing additional federal support into Medicaid, including FQHC, grants and programs to bring wellness and prevention as a key component of Medicaid;
   c. Increasing third party collections for Medicaid Managed Care Plans by providing access to other carrier data, including auto and BCBSM and designating Medicaid Health Plans as “agents of department” for purposes of this function.
   d. Improving fraud and abuse coordination through the Medicaid Inspector General Office and working with a variety of organizations regarding the development of more community based care to reduce current high cost utilization of care.
   e. Continue to develop an enhanced beneficiary monitoring program within managed care to effectively control high utilization of services while maintaining access.
   f. Developing an effective Observation Stay reimbursement policy and incentives for alternatives for Emergency Department use.
   g. Continue and expand efforts to support medical homes and other forms of diversion from emergency department inappropriate use.

8. The State of Michigan should assure that the full six years of the Medicaid Health Plan Contract Terms (3-year contract and all of the 3 one-year extensions) are completed.

EXECUTIVE SUMMARY

“Policy makers, administrators and the public expect (and receive) value from the Michigan’s Medicaid managed care program. This is largely due to the nature of the performance-based contract, the inherent flexibility of a managed care system, and the emphasis on prevention, care coordination and disease management. The most obvious strength is cost savings.”

Value in Managed Care

There continues to be an estimated savings of $400 million each year due to the Medicaid Managed Care program compared to fee for service. This savings has now yielded more than $5.0 billion in total savings between FY 00 and FY 12. The savings reflect the cumulative impact of competitive bidding, performance contracting, and more efficient management of health care in a partnership with the state in exchange for actuarially sound funding. This return on investment enables both the State of Michigan and the federal government to redirect savings from Medicaid managed care to support programs in other high priority areas while preserving access to quality health care services for the vulnerable populations served by Medicaid program.

What is even more of value is the high quality that is the hallmark of managed care. The continued high performance ranking of Michigan’s Medicaid Health Plans is a testament of the dedicated efforts of each of the health care partners in this arrangement; state administrators who
set the standards, providers who deliver the care as part of the provider networks, and contracting health plans who put it all together.

Once again, the Michigan Medicaid Health Plans have been cited as among the best in the nation by Consumer Report/NCQA America's Best Health Plans. Their 2012 ranking cited Michigan Health Plans for excellence in all three categories: commercial, Medicare, and Medicaid. Specifically, Michigan Health Plans are among 11 of the nation's top 100 Medicaid plans; 6 of which were in the top 25.

What’s next?

While there is still much more work to be done, MDCH and the Medicaid health plans have been very active in working through operational details and enrolling special populations into managed care to improve access, coordinate care and provide more cost effective and accountable care. This is in addition to the 1.2 million beneficiaries already enrolled in managed care. These special efforts already underway include:

- Completing the enrollment of Foster Care Children into managed care;
- Completing the transition of enrollment of Children’s Special Health Care Services, CSHCS that began October 1, 2012.
- Default enrollment of the Dual-Eligible Population into the Medicaid plans process for their physical health care services. (Separate from the MDCH/CMS Demonstration Initiative);
- Working with MDCH to implement a reimbursement increase for primary care providers—to a level consistent with Medicare. This program will be retroactive to January of 2013 and is 100% funded by federal dollars under the ACA and was part of the FY 13 enacted budget approved by the legislature.
- Working with MDCH to begin implementing (April 2013) an enhanced beneficiary monitoring program to effectively control beneficiaries with high utilization of services while maintaining access to needed care.

Limited Duals Initiative.

The experience of the Medicaid Health Plans in Michigan and confidence by the Department as illustrated by the activity cited above was a stepping stone for taking the next steps in assuring quality health care for Michigan’s vulnerable population—Michigan’s seniors who qualify for both Medicare and Medicaid services. As is well known, Michigan conducted an exhaustive stakeholder process over the past year to develop an approach of delivering integrated health care services for persons eligible for Medicare and Medicaid services—sometimes referred to as “Dual Eligible”. This effort is also seen as a way that we can begin to unify the delivery of physical and behavioral services.

The on-going negotiations with CMS since the April 2012 MDCH submission of the proposed plan of integration have now resulted in the tentative agreement for a regional demonstration project. As part of this demonstration, Michigan’s Health Plans will be competitively selected to
participate. The department will issue a Request for Proposal (RFP) in the near future with a very tight timeline to select carriers and have coverage available as early as January of 2014.

Since the targeted demonstration project will be functioning in 4 regions of the state (Wayne County, Macomb County, SW Michigan Region and the Upper Peninsula Region), there remains an opportunity for developing an integrative approach for long term care in the rest of Michigan to capitalize on the considerable work by health plans, members of the Health Care Association of Michigan, MI CHOICE waivers agencies, and others.

The coordination of services with behavioral systems managed by Prepaid Inpatient Health Plans would be assumed under this approach and would be a stepping stone for the rest of Michigan to prepare to participate in the fully Integrated Care for the Duals project that is being tested in the targeted regions.

**Medicaid Expansion**

This expansion could result in the addition of approximately 450,000 to 500,000 Medicaid lives added to the program over time, most if not all will be enrolled in managed care. However, like any other program the initial year of implementation is likely to reach at least \( \frac{2}{3} \) of the targeted population with full implementation in year two and forward. One of the stated concerns with the question of expansion has been the Medicaid Health Plans ability to provide additional capacity for this population.

![Primary Care Provider Capacity Ratio: Number of Beneficiaries divided by PCPs Open for Enrollment](image)

By reviewing existing provider capacity and identifying the total unduplicated number of providers open to Medicaid enrollment a PCP ratio is created. This PCP ratio of the currently contracted providers indicates there is sufficient capacity for this expansion when differing levels of expansion are calculated. Moreover, the Michigan State Medical Society and University of Michigan recently completed a survey of physicians and their willingness to accept new patients
under expansion. Their results also confirm that there is not only existing capacity to serve the additional enrollment—there is willingness to do so.

While Medicaid Health Plans continue to play a critical role in the movement of eligible populations into a more cost-effective and account system of care, there is more that can be done by both the State of Michigan and participating Health Plans. The efforts to increase enrollment into managed care will also increase the need to become more efficient in the eligibility process and overall contract administration in order to reduce unnecessary costs that are built into current systems. These efforts should include the following considerations described below:

**Reform Eligibility**

The sooner an eligible person becomes enrolled into a Medicaid Health Plan, the more effective and timely care can be provided and coordinated. A good example of where improvements can take place is with newborns. Now that the Medicaid Program has moved the Children’s Special Health Care Services, CSHCS, enrollment into managed care, it is critical that newborns be identified and enrolled into the same health plan as the mother in the birth month. While this provision is included in the Contract with Medicaid Plans, operationally it is always delayed for months and then creates retroactive enrollment during a critical period of time for coordinating care.

As we look to the new eligibility system that will be established for the expanded population under ACA—up to 133% of poverty (note—operationally it will be 138%) reform of the existing system should take place. Performance standards of care imposed on Medicaid Health Plans under the State’s Contract are more achievable with timely enrollment. It may be time to consider a Medicaid-only eligibility system rather than one in which other social support programs are linked. Other efforts should assure that the eligibility re-determination process becomes more transparent in order for Medicaid Health Plans to identify and assist beneficiaries. This effort will result in more continuity of care and improved date and accountability as HEDIS measures are based on “continuous enrollment” files.

**Streamline and Coordinate Administration and Oversight**

The Department should be commended for continuing to meet with Medicaid Health Plans on a regular basis to jointly discuss how the program can be improved. In addition to those conversations, the following areas should receive more attention over the next year:

- Merging contracts for MICHILD with Medicaid. This will eliminate some administrative costs, focus more on performance and accountability using the audited data requirements that exist for Medicaid, and would eliminate a current cost-settlement program with BCBSM that costs between $12 and $15 Million each year.
- Reduce paper requirements in lieu of access of electronic documents and web-based information sites.
- Continue the identification of areas that can be considered “deemed compliant” as a result of national accreditation and change the focus of contract oversight to raising the performance of those contractors that are under the state average.
• Coordinate efforts for identifying and managing beneficiaries who have high utilization of care, particular in emergency departments and in pharmacy.

Finally, as most of Medicaid beneficiaries are or will be enrolled in managed care, it is time for the development of Medicaid policy to be developed through the “lens” of managed care and not based on “fee for service”. Under the Medicaid Contract, once a policy is adopted, Medicaid Health Plans must comply. Often, this requires modifications of systems, adjustments of internal protocols and policies—all of which add administrative costs. Further, these policies are often developed after the annual rates for Medicaid Plans are approved by the CMS—therefore, costs must be absorbed within the existing rates—although were never part of the rate build up assumptions.

Maximize non-GF Revenue

The success of Michigan Medicaid has been largely related to the ability to identify and implement programs that establish non-general fund support. As a result, the overall state general fund support for Medicaid has stayed largely static over the past years—while overall enrollment has increased significantly. It is vitally important that this effort continues and be enhanced where possible. Medicaid Health Plans have been highly supported in several direct ways:

• Medicaid Health Plans continue to pay taxes to support Medicaid—first through a HMO Quality Assurance Assessment Program, QAAP; then through payments to the state’s use tax; and now as part of the Health Insurance Claims Assessment Act.
• Medicaid Health Plans provide transfer payments for Michigan’s Hospitals to account for uncompensated care and graduate medical education programs; to Specialty Programs to assure assess to care; to adolescent centers and programs to provide the core funding for teen health centers and health education curriculum.
• Medicaid Health Plans are expected to increase the identification and collection of third party insurance in order to reduce Medicaid exposure.

Additionally, the areas of fraud and abuse are areas that Medicaid Health Plans work closely with the Michigan Attorney General’s office and the Medicaid Inspector General—and expect to do so even more in the future years. Cost avoidance through this coordinated effort is one of the expected outcomes.

Finally, the area of “waste” is one area that is of concern to all payers. Health care reform cannot truly take place unless the cost of health care is reduced—this will affect Medicare, Commercial and Medicaid services together—and solutions should be seen not just as a Medicaid issue but much broader. We know that at many as 20% of admissions are for treatment and care that could be provided in a community outpatient setting—IF—such settings and programs were available. Efforts toward more medical homes and early treatment and interventions—prevention—will also reduce the costs. Finally, all citizens, including those on Medicaid need to have incentives to take personal responsibility for managing their own health care. The implementation of Michigan’s health and wellness plan—also known as the 4 X 4 Plan is a good start in this effort.
Avoid Costly Rebid

The Department of Community Health has many initiatives commencing in the current year and to continue into FY 14 which include:

1. Development of the plan for the Integrated Care for the persons with dual eligibility Project –now a regional demonstration which will require extensive negotiation with CMS along with necessary Waivers and/or state plan amendments. Procurement to competitively select health plans (RFP) will also be prepared, reviewed and contracts issued in the next several months.

2. The Michigan Market Place (the Insurance Exchange) will change the face of insurance selection for the citizens of Michigan and is under development through a federal partnership model with the federal government. Medicaid needs to be part of the systems development in order to coordinate the enrollment of expanded Medicaid eligibility.

3. Medicaid expansion will require a number of administrative activities, from the systems coordination (mentioned above) to statewide awareness campaigns, enrollment packages, and contract revisions with Medicaid Health Plans.

4. Under development is the new version of diagnoses codes, namely the ICD-10, an enormous system change undertaking in health care and costing already millions of dollars in system changes.

All of these initiatives require a tremendous amount of staff resources and expertise of both the state of Michigan and its consultants and the current and interested health plans who would submit proposals for review. MAHP continues to recommend that Michigan utilizes the full option of 3 one-year extensions and until the scheduled end date of September 30, 2015.

As documented further in this White Paper, the quality of the services provided by Medicaid health plans continues to be high as evident in the national rankings of the health plans. In addition, Medicaid health plans have and continue to document that they have adequate capacity to fulfill the needs of the current Medicaid population as well as the anticipated growth. Therefore, there is no need to re-bid this contract because of poor performance or unmet capacity. Using all of the 1-year extensions will save Michigan government millions in resources that can otherwise be used for priority purposes.

Summary

Continued support of Medicaid Managed Care and the movement of additional Medicaid beneficiaries into managed care continue to save Michigan dollars. The key points that MAHP will emphasize in various advocacy messages are the following:

- **Enrollment of Population Groups into Managed Care Saves Dollars and Improves Care.** In addition to the cost savings that the management of this population will realize, the actual care and treatment in a managed environment lends to better and more efficient health care as documented by external auditors and performance contract requirements by the State of Michigan.
• **Enrollment of Population Groups into Managed Care creates Administrative Efficiencies.** With the multiple initiatives and programs occurring in the Medicaid program, movement toward a single benefit contract covering all of the programs creates administrative cost savings. We believe further state oversight responsibility and contract management could be consolidated for more efficient administration of programs. Coupled with electronic capabilities and other streamlined tools for contract management, a realization of savings to the contractors and thus a savings in the cost of the contracts would be accomplished.

• **Enrollment of Population Groups into Managed Care will reduce Fraud and Abuse expenses and highlight savings potential that will reduce “Waste”**. There are various best practice models for state governments to address the ever present fraud and abuse from the Medicaid beneficiary as well as some Medicaid providers. Michigan Medicaid applies these best practices which creates a significant health savings without compromising the quality of care or access to care.

In addition, studies have indicated that there are areas of potential savings if the waste in our health systems could be addressed. For example, Medicaid hospital utilization is significantly higher than the commercial utilization. By lowering that difference we could save millions of dollars. Examples of initiatives to address this hospital utilization are to tackle of the problem of readmissions to the hospital within 30 days of discharge and the development of a workable observation room policy.

Another initiative taking place in the Medicaid program is the enhancement and enforcement of the Beneficiary Monitoring Program. The Medicaid health plans will be involved in this program and will be able to monitor and sanction Medicaid beneficiaries who do not follow Medicaid protocol and abuse the system. This will create a cost savings by virtue of avoidable Emergency Department visits and pharmacy management.
I. Creating Value for the State of Michigan

Expectation of Performance

In this environment, MAHP believes it is not possible to view the Medicaid program separate from overall delivery of health care in Michigan. Similarly, those who advocate for federal and state reform must include a vision of the future of Medicaid. The longstanding expectation of MAHP is that overall health care (including Medicaid) will reflect the following elements:

- Improved access to affordable choices for all citizens.
- Protection of the safety net (Medicaid and MIChild)
- Linking payment to quality and performance outcomes.
- Cost containment that addresses overuse/underuse/misuse of health care resources.
- Transparency in pricing and provider rates.
- Personal accountability and wellness as part of a “value based benefit design” model
- Standardization and efficiency through technology

The value of Managed Care results from providing the right amount of health care, at the right time, in the right setting. Focusing on prevention and providing alternatives to high cost services and settings while maintaining quality are among the objectives of all managed care organizations — and particularly the focus of Medicaid health plans.

Unlike other service providers or contracts in the Medicaid program, Medicaid managed care operates in a performance-based environment under a full risk model. Medicaid health plans rely on data from their encounter and claims systems to identify high-cost conditions and cases and then target these conditions through programs and interventions designed to ensure quality care while at the same time reducing costs. Attachment 3 of this White Paper lists a variety of the administrative tools used by Medicaid health plans in quality assurance and improvement initiatives. The development of quality improvement initiatives, led by health plan medical directors and quality improvement directors, are predicated on evidence-based models of care and guidelines. It is these guidelines and protocols that improve quality and access and, importantly in today’s environment, save dollars.

Medicaid health plans either participate in the Michigan Quality Improvement Committee (MQIC), a consortium of medical directors of health plans organized to establish a common set of guidelines, or use the outcomes of MQIC\(^1\). Other evidence-based guidelines come from the United States Preventive Health Task Force, whose work can be found on the following website: http://www.ahrq.gov/clinic/uspstfix.htm

It is therefore no surprise that the business plans of Medicaid health plans are based on key strategies that emphasize the following:

- A focus on preventive health care;
- Coordinated disease management;

\(^1\) The MQIC website is located at: http://www.mqic.org/guid.htm
• Effective management of utilization;
• Key indicators for improved health status of beneficiaries;
• Assurances that access to care for members is available;
• Quality monitoring of performance;
• Preferred pricing arrangements that emphasize improvement in care; and
• Claims management, coordination of Benefits, and protection against fraud and abuse.

Reducing Hospital Utilization

Providing the right amount of care in the right setting often means more physician and ambulatory visits. Chart 1 outlines the trend in utilization in those settings for Medicaid Health plan and also is a clear indication of the access for services by Medicaid beneficiaries.

The potential for moving further in this direction is highlighted by data produced by the Michigan Department of Community Health\(^2\). This data has documented the extent of preventable hospitalizations in Michigan by condition, age and gender. High rates of Ambulatory Care Sensitive hospitalizations in a community may be an indicator of a lack of or failure of prevention efforts, a primary care resource shortage, poor performance of primary health care delivery systems, or other factors that create barriers to obtaining timely and effective care.

This set of preventable hospitalizations is further illustrated by the conditions listed in the Table below. The information is not intended to indicate that the hospital care was not appropriate — this information is intended to indicate that the admission itself was not necessary — IF — appropriate alternatives had been in place.

\(^2\) See MDCH Web site Report for Preventable Hospitalizations: [http://www.mdch.state.mi.us/pha/osr/CHI/HOSP/PHT7TT.ASP](http://www.mdch.state.mi.us/pha/osr/CHI/HOSP/PHT7TT.ASP)
Ambulatory Care Sensitive Hospitalizations and Rates per 10,000 Population
For Patients of All Ages—Michigan Residents, 2005-2010

<table>
<thead>
<tr>
<th>AMBULATORY CARE SENSITIVE CONDITIONS</th>
<th>HOSPITALIZATIONS</th>
<th>RATE PER 10,000 POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average Annual Number for 2005-2009</td>
<td>2010</td>
</tr>
<tr>
<td>ALL AMBULATORY CARE SENSITIVE CONDITIONS</td>
<td>267,482</td>
<td>265,255</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>40,044</td>
<td>36,655</td>
</tr>
<tr>
<td>Bacterial Pneumonia</td>
<td>34,820</td>
<td>30,495</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary</td>
<td>24,028</td>
<td>26,076</td>
</tr>
<tr>
<td>Kidney/Urinary Infections</td>
<td>16,141</td>
<td>17,949</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>14,997</td>
<td>16,284</td>
</tr>
<tr>
<td>Asthma</td>
<td>16,402</td>
<td>15,471</td>
</tr>
<tr>
<td>Diabetes</td>
<td>12,336</td>
<td>13,646</td>
</tr>
<tr>
<td>Grand Mal &amp; Other Epileptic Conditions</td>
<td>4,834</td>
<td>7,601</td>
</tr>
<tr>
<td>Dehydration</td>
<td>9,044</td>
<td>6,414</td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>4,001</td>
<td>3,964</td>
</tr>
<tr>
<td>All Other Ambulatory Care Sensitive Conditions</td>
<td>90,835</td>
<td>90,700</td>
</tr>
</tbody>
</table>

*Ambulatory Care Sensitive Hospitalizations* are hospitalizations for conditions where timely and effective ambulatory care can decrease hospitalizations by preventing the onset of an illness or condition, controlling an acute episode of an illness or managing a chronic disease or condition. **Hospitalizations** are inpatient hospital stays as measured by stays that were completed during the specified year. The number of hospitalizations is often greater than the number of persons hospitalized since some persons are hospitalized more than once during a year.

While this represents a snapshot of all of Michigan’s population and hospitalizations in 2010, it is not difficult to picture the targeted areas for Medicaid that would include such conditions as asthma and diabetes, (conditions that already have well-developed case management programs used in managed care programs).

Overall, the Department has projected in its most recent update that many of hospitalizations are preventable. That is, the hospitalizations taking place are for conditions where timely and effective ambulatory care can decrease the number of admissions by preventing the onset of an illness or condition, controlling an episode, or proactively managing chronic disease/condition.

This point was highlight earlier this year in a release of a study in the January 23rd issue of the *Journal of the American Medical Association (JAMA)*. This study illustrated that hospitalizations and re-hospitalizations among Medicare patients declined nearly twice as much in communities...
where Quality Improvement Organizations (QIOs) coordinated interventions that engaged whole communities to improve care than in comparison communities. The results show that interventions aimed at improving care transitions—when patients move from one care setting to another, such as from a hospital to their home or a nursing facility—reduced re-hospitalizations for Medicare patients in 14 select communities nationwide, including in Lansing. While the study was specific to the Medicare Population, the results are instructive for changes that should be supported in Medicaid.

The 14 communities in the study averaged a 5.7 percent reduction in re-hospitalizations. A less expected result was that Medicare beneficiaries in the communities also experienced a 5.74 percent reduction in hospitalizations over the two-year period. In Lansing, there was a 4.17 percent reduction in re-hospitalizations of Medicare patients and a 4.02 reduction in hospitalizations.

Chart 2 and 3 also illustrates a point that bears repeating—that is, the Medicaid population has generally more acute illness and while overall admissions may be less than commercial populations—overall days of care are much more.
Chart 4 highlights a problem that cuts across all payers—that is, an increasing number of people are using hospital emergency departments (ED) for non-urgent care and for conditions that could have been treated in a primary care setting.

Nationally, 56 percent, or roughly 67 million visits, are potentially avoidable according to the National Quality Forum. Reducing this trend represents a significant opportunity to improve
quality and lower costs in health care. Chart 4 shows the use in Medicaid managed care—a way that remains too high. According to the National Quality Forum, the average cost of an Emergency Department visit is $580 more than the cost of an office health care visit—suggesting considerable savings may be realized. What can be done?

Steps are already underway for some solutions in reimbursement and primary care improvements (Patient Centered Medicaid Homes, extended hours for Primary care offices, and additional use of tele-health. Additional steps to be considered may be in performance based standards for Health plans, incentives for providers, and reductions in co-payment for beneficiaries who used urgent care sites rather than emergency departments. What is also necessary is more accurate data and access in real time to emergency department visits.

The final challenge in cost-efficiency is in the management of pharmacy benefit. Chart 5 outlines the current use of Pharmacy—where beneficiaries in managed care average about 11 prescriptions per year. Overall spending on pharmacy has been relatively modest (3.6% nationally in 2010)—but this masks the significant increases taking place in specialty drug spending. Specialty drugs expenses has increased nationally by 19.6% in 2010 and projected by 2016 to have most of the top 10 drugs spending in this category.

Medicaid remains one of the largest markets for prescribed drugs ($25 billion nationally)—however these outlays are offset by manufacturer rebates at the federal and state level—that totaled nearly 10 billion of total pharmacy spending. Further savings are exacted from generics—and Medicaid managed care has historically been prominent in the use of generic prescriptions—however, this is not the case in specialty drugs.
Additionally some of the costs for specialty drugs show up as medical expense due to the setting in which it is provided. Some additional strategies include contracting with specialty drug vendors and re-tooling pharmacy claims processing systems with paid medical claims. This will remain an area that Medicaid Health plans and the Medicaid program must work together on to control the increasing use and costs.

Therefore, while appropriate access to Michigan’s hospitals for necessary use of care is part of overall management of care, a more cost effective approach will require the development and use of community based outpatient alternatives—many of these interventions are now underway. Likewise for delivery a more cost-effective pharmacy program, increased management options to incent the use of generics need to be sustained and all participants need to address the alarming increased use in specialty drugs and how it is administered in both the pharmacy and medical settings.

II. Building the Infrastructure for Medicaid Managed Care

Cost-effective health care, high quality health care and improved access to health care: these are terms that continue to describe the demonstrated and audited outcomes of the Michigan managed care program. Translated into monetary terms, this means $350-400 million in annual savings for Michigan tax payers, improved health status measures for adolescents and adults, and greater access to needed health care services.

Recent History

Through competitive bidding (that began in 1997 in SE Michigan; in 1998 for the remainder of state; 2000, 2004 and again 2009 statewide), the Medicaid managed care program has provided the following results:

1. **Medicaid managed care expenditures are managed and predictable.** An immediate savings of about $120 million to the state occurred for the FY 1997-1998 budget — a savings that has grown to an estimated $400 million annually as nearly 2/3 of all Medicaid beneficiaries are now enrolled in this program. Despite the fact that Medicaid remains an entitlement program, beneficiaries’ expenditures are capped in Medicaid managed care and total payments may only increase by caseload changes. While rates have been adjusted over time to assure actuarial sound funding, the savings to the state compared to the previous program (fee-for-service) have grown substantially.

   **Per Member per Month Increases: Managed Care vs. Fee-for-Service**

   Unlike Medicaid managed care program, the state has little or no ability to control utilization, technology and other health care cost “drivers” in fee-for-service that result in increased and uncontrollable expenditures. Due to the growth in managed care enrollment, the percent of managed care expenditures has grown to over 25% of total Medicaid expenditures. However, without the cost-effectiveness of Medicaid managed care, the expenditures in fee-for-service would have increased substantially (more than
Is there opportunity to extrapolate the principles of managed care to other segments of the Medicaid program? The answer to that question is “yes,” most notably in long-term care and disabled populations. As noted by many observers, the most significant cost increases in Medicaid are taking place in these two areas and efforts are under way for demonstration projects for “Duals” and to move the Children’s Special Health Care Services Program into managed care.

The two-thirds of Medicaid beneficiaries enrolled in managed care (see Chart 6) are now in an environment that provides predictable savings to the state by virtue of being enrolled in Medicaid health plans. The remaining 1/3 of beneficiaries are in settings that present significant opportunity for additional cost control and savings comparable to those implemented by managed care for the State of Michigan.

2. **Services provided by Medicaid health plans are accountable under terms of both the state’s contract and the HMO requirements in the Insurance Code.**

There are five major elements to the Medicaid managed care program that give meaning to “accountability.” The first element is the use of audited data related to the clinical quality of care. Among the sources for this is the data developed for the National Committee on Quality Assurance (NCQA). This data is known as the Health and Employer Data Information Set.
(HEDIS®). HEDIS® data is collected for both commercial and Medicaid products provided by health maintenance organizations. External auditors, certified by the NCQA, are used by HMOs to process administrative and medical record data for various key measures.

An illustration of the improved performance of Medicaid health plans has been in the area of immunizations. Through the use of HEDIS® data, comparisons are made regarding the relative performance of Medicaid managed care programs to the industry average in Michigan as well as to national Medicaid averages. No other segment of the health care industry reports on as broad a range of clinical measures. The most current HEDIS® reports are available on following URL: http://www.michigan.gov/mdch/0,4612,7-132-2943_4860--,00.html

Under the HEDIS® analysis, key areas are reviewed each year — immunizations being one area. NCQA has now developed national Medicaid averages that states can use for comparison purposes. As displayed in Chart 7 below, the Michigan Medicaid managed care average immunization rate has increased by nearly 33% since 2003 but must be improved.

Further, the performance by Medicaid health plans enabled Michigan’s overall performance in immunizations to leap forward over the past several years from nearly last in the United States to being one of the top performing states. Another example of audited data showing clinical quality outcomes is diabetes. As Chart 8 illustrates, the basic diabetic testing rate has increased substantially over the past several years and is above the comparable Medicaid national average.
Another area is prenatal care which has always been a marker in the determination of safe and healthy deliveries and reducing infant mortality rates. Medicaid Health Plans have emphasized prenatal care, and the results are illustrated in Chart 9.

Over 50 percent of births are Medicaid births. The importance of prenatal care as mentioned above is critical. However, in order to have as much management and preventive services available for pregnant women and help managed pregnancies to achieve healthy outcomes; the timeliness of enrollment becomes a factor. Chart 10, highlights this issue in Michigan.

The state policy is to have “presumptive” eligibility for Medicaid at the time of pregnancy. The earlier in the pregnancy that enrollment can take place, the sooner the overall management of care by the health plan will be undertaken. Unfortunately, many women do not become eligible under well into their second trimester or later, and the enrollment process (under current system) may take another 60 days. This often results in continuity of care issues in the pregnancy and for the care of the newborn after delivery.

Chart 10 provides the latest data on enrollment of pregnant women. For the calendar year 2012, 28 percent of pregnant women were already enrolled in a health plan; 9% became enrolled during the first trimester; 41% during the second trimester; and 19% in the third trimester. While
these numbers are improving, efforts to address Michigan’s infant mortality will depend in large part to moving the percentages toward enrollment in the first trimester.

![Chart 9: Timeliness of Prenatal Care in Medicaid Managed Care](chart9)

![Chart 10: Percent of Pregnant Women Enrollment by Weeks of Pregnancy](chart10)

Another example that illustrates improvement in services for a condition that is common for Medicaid, particularly for children — asthma — is displayed below in Chart 11. Michigan’s
Medicaid Health Plans are measured by a number of performance standards for different populations served, including the NCQA’s “Use of Appropriate Medications for People with Asthma” performance measure. This measure examines how many people diagnosed with asthma are prescribed short- or long-acting medications needed to manage the condition.

This measure reflects the percentage of members aged 5-50 years who were identified as having persistent asthma and who were prescribed recommended medications during the measurement year. Because asthma is estimated to be responsible for more inpatient hospitalizations than any other childhood disease for those aged 5-17 this is a very important measure. Most of the children who participate in Medicaid are in a Medicaid Health Plan and expectations are very high that the Medicaid Health Plans will not only provide access to care—but will assure that that accessibility also results in appropriate care for conditions such as asthma.

Further, because asthma control usually requires multiple medications and management of the environment, care must be coordinated among physicians and community resources—a service provided by Medicaid health plans. To keep the performance measures high, Medicaid health plans support patients by facilitating this care coordination and tracking “medication possession” by members to identify when members are not refilling asthma medications or using high levels of rescue medications.

Finally, and consistent with Governor Snyder’s dashboard objectives for obesity and health and wellness in Michigan are two performance measures: the measurement of the percent of adults
who have their BMI documented during a physician or ambulatory encounter during the enrollment year and the measure of adults receiving assistance for stop smoking.

As illustrated in Chart 12 below, significant progress has taken place in the BMI measure for adults. Body Mass Index (BMI) is a number calculated from a person's weight and height. According to the Centers for Disease Control, BMI is a fairly reliable indicator of body fatness for most people. However, while BMI does not measure body fat directly, research has shown that BMI correlates to direct measures of body fat, such as underwater weighing and dual energy x-ray absorptiometry (DXA).

![Chart 12: Percent of Enrolled Adults in Managed Care with BMI Documentation](chart.png)

Calculating BMI is one of the best methods for population assessment of overweight and obesity. Because calculation requires only height and weight, it is inexpensive and easy to use for clinicians and for the general public. The use of BMI allows people to compare their own weight status to that of the general population.

BMI is used as a screening tool to identify possible weight problems for adults but is not a diagnostic tool. For example, a person may have a high BMI. However, to determine if excess weight is a health risk, a healthcare provider would need to perform further assessments. These assessments might include skinfold thickness measurements, evaluations of diet, physical activity, family history, and other appropriate health screenings. The CDC has created the following link for individuals to see how BMI is calculated and interpreted: [http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html#Interpreted](http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html#Interpreted)

Rhigan continues to have too high of percentage of adults who smoke. According to the U.S. Surgeon General, “Smoking cessation [stopping smoking] represents the single most important step that smokers can take to enhance the length and quality of their lives.” As is well
documented, smoking is associated with a myriad of health issues, including increased cancer, lung and heart disease rates.

Given the special enrollment population in Medicaid of pregnant women, it is vitally important emphasis be placed in multi-faceted stop smoking initiatives and interventions. Women over 35 who smoke and use birth control pills have a higher risk of heart attack, stroke, and blood clots in the legs. Women who smoke are more likely to miscarry (lose the baby) or have a lower birth-weight baby. Low birth-weight babies are more likely to die or have learning and physical problems. Michigan’s strategy for reducing infant mortality rates has stop smoking as a key element.

Fortunately, stop smoking is an effective strategy for individuals at any age. No matter how old you are or how long you’ve smoked, quitting can help you live longer and be healthier. People who stop smoking before age 50 cut their risk of dying in the next 15 years in half compared with those who keep smoking. Ex-smokers enjoy a higher quality of life. They have fewer illnesses like colds and the flu, lower rates of bronchitis and pneumonia, and feel healthier than people who still smoke. According to the Surgeon General:

- Quitting smoking has major and immediate health benefits for men and women of all ages. These benefits apply to people who already have smoking-related diseases and those who don’t.
- Ex-smokers live longer than people who keep smoking.
- Quitting smoking lowers the risk of lung cancer, other cancers, heart attack, stroke, and chronic lung disease.
• Women who stop smoking before pregnancy or during the first 3 to 4 months of pregnancy reduce their risk of having a low birth-weight baby to that of women who never smoked.

The second element is the use of external measures to determine customer satisfaction. Again, the standard used in Michigan is the customer services satisfaction survey of the NCQA. This survey is known as Consumer Assessment of Health Plan Survey, (CAHPS). This is a tool that is used for both commercial and Medicaid products; however, the adolescent component of CAHPS is only available for the Medicaid program and is now conducted every other year. MDCH summarizes all of this information into a Consumer Guide provided to new beneficiaries in Medicaid who are then presented with choices for health plan selection.

The third element for accountability is the use of performance standards. These standards are specific to Michigan and are reviewed and revised each year by the MDCH to reflect important categories of service. An example of the dynamic nature of this area, MDCH developed a new performance standard for blood-lead screening rates for health plan performance consistent with the standard specified in recent legislation.

As outlined in Chart 14, Medicaid health plans have recorded over a 60% increase in the screening rate objective established under legislation.

![Chart 14: Blood Lead Screen Rates: Medicaid Managed Care and Medicaid Fee For Service](image)

Accountability to the state under terms of the contract has made a difference in this area. This is more outstanding when compared to measures in the fee-for-service environment of Medicaid at the same time. The illustration demonstrates the power of accountability. Unfortunately, we have
no similar measures in other programs, such as the MI-CHILD program — although many of those enrolled in MI-CHILD live in the same targeted zip codes of Michigan that have the same high levels of exposure to lead as Medicaid beneficiaries.

This accountability has also been recognized nationally as Michigan’s Medicaid health plans were recognized again by the NCQA in October of 2012 as having 10 of the 50 top ranked Medicaid plans in the United States based upon performance scores. [http://www.consumerreports.org/health/insurance/medicaid-1.htm](http://www.consumerreports.org/health/insurance/medicaid-1.htm) for Medicaid HMO rankings

The fourth element for accountability is the reporting requirements established under the state contract — coupled with reporting requirements required as a licensed HMO. Unlike other health care providers, the reporting requirements are significant and are a matter of public record. The reporting addresses such major areas as:

- utilization of services of enrolled members (monthly encounter reporting);
- customer satisfaction (semi-annual Complaint and Grievance Reports);
- claims payment (monthly claims reporting to DCH and quarterly reporting to OFIR relative to denied claims, and Third Party Liability Reports);
- financial reporting (quarterly and annual filings with OFIR — available on the OFIR Web site).

The fifth element is external accreditation from national organizations. All Medicaid health plans are nationally accredited by either the National Committee on Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC). This assures the public that Medicaid health plans are providing value and accountability and are subject to the external auditing process of the national accrediting bodies.

Additional accountability is provided through:
- external quality reviews under contract from MDCH, (medical record reviews provided by a vendor approved by the federal government);
- annual site visits by both DCH and OFIR;
- program audits performed by the Michigan Auditor General’s Office;
- federal waiver review conducted by the Federal Centers for Medicare and Medicaid Services (CMS);

3. **Greater access to care is provided for enrolled beneficiaries and customer service is assured.**

   It is essential that each Medicaid beneficiary have a “medical home.” Access to primary care providers (PCPs), as well as choice among PCPs, are the hallmark of the managed care program and provide this “medical home.” Also, as shown below, and earlier in Chart 1, beneficiaries have increased access to primary care physicians, indicating continued access to care. Access to care is one of the key performance standards for Medicaid Health Plans and one that is measured on a monthly basis.
Medicaid Health Plans are required to submit updated provider files to MI ENROLLS on a monthly basis. It is these files that MI ENROLLS relies on to provide information to Medicaid beneficiaries regarding choices for health plan enrollment and selection of a primary care provider. Because the files are updated monthly and provide information on which providers are open for additional Medicaid beneficiary selection, it is possible to develop an overall view for Michigan.

Using an unduplicated count from the MI ENROLLS provider files, Chart 15 illustrates the trend in primary care provider, PCP to beneficiary ratio. In noting this, it is worth putting the ratios in the context of the threshold used by the federal government in determining shortage areas—which is a ratio of 1:1500.

Medicaid beneficiaries today have access to about 40% more physicians when compared to the physicians enrolled in the former Medicaid Physician Sponsor Plan in operation during the mid-1990s prior to the implementation of Medicaid managed care. This is due to the ability of health plans to contract with systems and physician organizations that bring more physicians to participate with Medicaid compared to fee-for-service.

One of the key questions to be asked and answered before implementing the option for Michigan to implement the Medicaid expansion of eligibility is provider capacity. Using the same documentations as listed for Chart 15 above, an analysis was undertaken to determine what the PCP to beneficiary ratio might be under differing expansion scenarios between 250,000 to 500,000 additional beneficiaries.
This analysis clearly shows that the existing capacity contracted to Medicaid Health Plans will serve the new population. This was recently augmented by a University of Michigan and Michigan State Medical Society survey of physicians that also indicated the vast majority of physicians would serve the expanded population.

![Chart 16: Primary Care Provider Capacity Ratio: Number of Beneficiaries divided by PCPs Open for Enrollment](chart)

4. **Administrative functions are built into state contract.**

To gain cost predictability and control without sacrificing medical benefits and to improve quality, the state engaged Medicaid health plans to perform functions that had previously never been performed for Medicaid beneficiaries. The underlying administrative infrastructure that is required for each HMO must be understood as critical to their ongoing performance and part of what insulates the state from open-ended expenditures. More simply put, it is this structure that continues to generate the state’s savings realized through Medicaid managed care.

Administrative costs savings have been created through efficiency in operations and continuous quality improvement practices. Because the state’s contract allocates the number of approved plans for each of the ten regions, the number of health plans selected in each region is limited to the capacity sought by the state. That capacity is established each time the contract is bid as illustrated in the graph below.

Historically, in the Medicaid fee-for-service program, the state’s major administrative functions were to issue monthly ID cards, enroll providers and to pay claims. In that environment, no effective cost controls existed either as to unit or utilization cost increases and as a result, state budget expenditures increased significantly from year to year and were unpredictable.
Additionally, the state under fee-for-service does not provide case management services to managed high-cost cases and facilitate improved health outcomes.

An Administrative Function Table is attached to the end of this paper (Attachment 3). It describes administrative “functions” required under the Medicaid contract. Costs associated with these “functions” are not included in those costs labeled “medical costs” or “medical loss ratio;” those measures typically are used to identify how much of the premium dollar received by an HMO is spent on direct health care delivery services.

The cost for the “administrative functions” outlined in Attachment 3 is inherently necessary in order to establish and sustain the improved delivery of services for Medicaid beneficiaries. These functions are consistent with the objectives prescribed by the state and to continue to provide the best value for the State of Michigan. Reporting on administrative costs is part of the annual filings with the Office of Financial and Regulatory Services.

By virtue of the state’s contract, each Medicaid health plan has “purchased” all of the risk from the State of Michigan to provide all services and meet the technical and quality requirements of the contract. While most observers are familiar with the medical benefits included in the HMO contract, many have not linked the essential fact that the costs and expenditure savings results that have been achieved are the product of “administrative costs.”
It other words, the state’s return on investment — the improved health status and access to care as documented in this paper and the hundreds of millions of dollars in savings compared to Medicaid fee-for-service — would not be possible without the investment in the Medicaid managed care infrastructure supported by administrative costs.

Summary

The information and data in this White Paper are intended to provide an overall illustration of how the Medicaid health plans are able to achieve the cost savings and quality of care ratings. The reader should also understand that this program has achieved a benchmark status not only in terms of its value by any measure — but also by its potential to serve as a guide for further improvements in the overall Medicaid program.

It is critical that this benchmark remain viable in its partnership with the State of Michigan. The state’s obligation to administer this program in an actuarial sound manner is of paramount importance. The Michigan Association of Health Plans and its members recognize the resource constraints facing the state and have proposed recommendations found on the following pages that can permit this program to be continued funded under the federal requirements.
III. RECOMMENDATIONS FOR FY 14 AND BEYOND

1. The State of Michigan should continue to assure actuarially sound rates as the underlying principle in support of Medicaid Managed Care. All Medicaid Policy bulletins issued by the Department after “Actuarial Soundness” federal approval should include economic analysis to demonstrate that the approved rates are not compromised by proposed changes in Medicaid Policy.

2. The State of Michigan should implement the option to expand Medicaid Eligibility to 133% of Poverty.

3. The State of Michigan should renew the Health Insurance Claims Assessment, HICA, Act by extending or repealing the current sunset (December 31, 2013)—while maintaining a rate of no more than 1%.

4. The State of Michigan should consider implementing an Integrated Long Term Care Initiative to parallel the implementation of the CMS/MDCH Initiative for Dual Eligibles that will now be limited to 4 regions of the state.

5. The State of Michigan should continue to improve and reform Medicaid eligibility by:
   a. Operationally, creating a default eligibility and enrollment for newborns to be assigned to the same Medicaid health plan as the mother at the time of birth (consistent with the terms of the Medicaid Contract).
   b. Considering the option to delink Medicaid application from other human services program applications in order to accelerate eligibility and enrollment.
   c. Implement a user-friendly system for beneficiaries and Medicaid Health Plans for determining expanded Medicaid eligibility and enrollment choices at the time of eligibility—similar to the system used for enrollment of MI CHILD.
   d. To help reduce enrollment and eligibility “churning”, Michigan should consider the feasibility of implementing either a bridge plan or basic health plan in conjunction with the Insurance Exchange.

6. The State of Michigan should continue their efforts in streamlining and coordinating the administration and oversight of Medicaid Health Plans and related contracted entities by:
   a. Merging the state administered contracts for MI CHILD and Medicaid Health Plans at the next earliest opportunity;
   b. Reduce or eliminate paper requirements in lieu of electronic documents and web-based information sites and begin using “deemed compliance” by virtue of national accreditation such as NCQA or URAC; and
   c. Changing the regulatory perspective to a “regulation by exception”—that is focused on contractors who may not be meeting standards established in the contract.

7. The State of Michigan should continue efforts to maximize all levels of non-GF Revenue (Federal, special use, local revenue, and cost avoidance) to protect Michigan’s Safety Net. This focus would continue and expand efforts for:
a. Medicaid Health Plan Special Access and Supplemental Programs to assure outreach and coverage for Medicaid beneficiaries;
b. Securing additional federal support into Medicaid, including FQHC, grants and programs to bring wellness and prevention as a key component of Medicaid;
c. Increasing third party collections for Medicaid Managed Care Plans by providing access to other carrier data, including auto and BCBSM and designating Medicaid Health Plans as “agents of department” for purposes of this function.
d. Improving fraud and abuse coordination through the Medicaid Inspector General Office and working with a variety of organizations regarding the development of more community based care to reduce current high cost utilization of care.
e. Continue to develop an enhanced beneficiary monitoring program within managed care to effectively control high utilization of services while maintaining access.
f. Developing an effective Observation Stay reimbursement policy and incentives for alternatives for Emergency Department use.
g. Continue and expand efforts to support medical homes and other forms of diversion from emergency department inappropriate use.

8. The State of Michigan should assure that the **full six years of the Medicaid Health Plan Contract Terms** (3-year contract and all of the 3 one-year extensions) are completed.

**MAHP Recommendation Principles**

Continued support of Medicaid Managed Care and the movement of additional Medicaid beneficiaries into managed care continue to save Michigan dollars. The key points that MAHP will emphasize in various advocacy messages are the following:

- **Enrollment of Population Groups into Managed Care Saves Dollars and Improves Care.** In addition to the cost savings that the management of this population will realize, the actual care and treatment in a managed environment lends to better and more efficient health care as documented by external auditors and performance contract requirements by the State of Michigan.

- **Enrollment of Population Groups into Managed Care creates Administrative Efficiencies.** With the multiple initiatives and programs occurring in the Medicaid program, movement toward a single benefit contract covering all of the programs creates administrative cost savings. We believe further state oversight responsibility and contract management could be consolidated for more efficient administration of programs. Coupled with electronic capabilities and other streamlined tools for contract management, a realization of savings to the contractors and thus a savings in the cost of the contracts would be accomplished.

- **Enrollment of Population Groups into Managed Care will reduce Fraud and Abuse expenses and highlight savings potential that will reduce “Waste”**. There are various best practice models for state governments to address the ever present fraud and abuse from the Medicaid beneficiary as well as some Medicaid providers. Michigan Medicaid applies these best practices which creates a significant health savings without compromising the quality of care or access to care.
In addition, studies have indicated that there are areas of potential savings if the waste in our health systems could be addressed. For example, Medicaid hospital utilization is significantly higher than the commercial utilization. By lowering that difference we could save millions of dollars. Examples of initiatives to address this hospital utilization are to tackle the problem of readmissions to the hospital within 30 days of discharge and the development of a workable observation room policy.

Another initiative taking place in the Medicaid program is the enhancement and enforcement of the Beneficiary Monitoring Program. The Medicaid health plans will be involved in this program and will be able to monitor and sanction Medicaid beneficiaries who do not follow Medicaid protocol and abuse the system. This will create a cost savings by virtue of avoidable Emergency Department visits and pharmacy management.

This agenda is doable, but will require action to:

- Amend state Medicaid waivers,
- Develop new waiver/state plan amendments,
- Develop enabling state legislation in such areas as TPL, and various mental health, public health and insurance code, and
- Re-deploy state employees into a consolidated administrative structure to administer and conduct appropriate oversight of the new contract mechanism.

Summary

This Paper started with the premise of expectations as cited below. It is our hope that the history of performance that has been highlighted in many charts and graphs within this White Paper will give Michigan’s policy makers the confidence to continue the expansion of existing Medicaid populations into managed care as well as to undertake the option of expanding Medicaid eligibility. MAHP is confident that the value of this investment will be returned to the state in the form of improved health status and continued cost savings for citizens of this state.

“Policy makers, administrators and the public expect (and receive) value from the Michigan’s Medicaid managed care program. This is largely due to the nature of the performance-based contract, the inherent flexibility of a managed care system, and the emphasis on prevention, care coordination and disease management. The most obvious strength is cost savings.”
Medicaid White Paper References

In addition to the references listed below, MAHP has depended on the following websites for ongoing information on various issues on federal reform, emerging health care issues, and published findings of best practices. We also encourage readers to visit the MAHP Website for news and findings: www.mahp.org

Frequently Used Medicaid Related Website Links:

- Commonwealth Fund Publications: http://www.commonwealthfund.org/Publications.aspx
- Americas Health Insurance Plans, AHIP, Research Center: http://www.ahipresearch.org/
- National Association of State Medicaid Directors: http://hsd.aphsa.org/Home/home_news.asp
- Centers For Medicare and Medicaid: http://www.cms.gov/home/medicaid.asp


22. October 2007, The Lewin Group, “Programmatic Assessment of Carve-in and Carve-out arrangements for Medicaid Prescription Drugs,


(Note: Much of the data used for the Charts contained in the White Paper are based on the publicly available reports to MDCH and OFIR. Additionally, MAHP has collaborated with Sanofi-Aventis to produce a publication, “Managed Care Digest Series/Michigan HMO Data Summary. These have been produced since 2003 and are distributed as part of the annual Summer Conference of MAHP. Interested parties may contact MAHP to obtain the most recent copies of this publication.)
ATTACHMENT 1 — STRATEGIES FOR ADDITIONAL PROGRAM FLEXIBILITY

The strategies listed in this attachment are an attempt to provide legislators and policy makers with additional options for program improvements in Medicaid overall, and ways of providing more cost effective services that will benefit the state budget. Some of these options will require federal waivers—and have been suggested by other state and national organizations. Other options would simply require state administrative or legislative approval.

<table>
<thead>
<tr>
<th>Potential Savings Suggestion</th>
<th>Comments</th>
<th>Operational Feasibility of Implementation</th>
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<tbody>
<tr>
<td><strong>BENEFIT/COVERAGE ADMINISTRATION AND MODIFICATION IN MEDICAID</strong></td>
<td></td>
<td>Medium</td>
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<tr>
<td>1. Establish a <strong>default formulary in Medicaid of generic Rx</strong> with exceptions for psychotropic pharmaceuticals without generic replacements.</td>
<td>The current State Medicaid formulary is open ended and is based on selections that provide the most attractive rebates to the state and not necessarily the most effective products for beneficiaries. Considerable savings have taken place through the emphasis on generic drugs and the State’s Medicaid Formulary should establish the principle of generics as primary tool. Most health plans are now paying for more than 80% generics of all prescriptions.</td>
<td>Medium</td>
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<tr>
<td>2. <strong>Limited Benefit Arrangement.</strong> Federal policy (Deficit Reduction Act, DRA) permits states to have a differing benefit plan for certain optional populations. Michigan should look at the feasibility of such a plan. Under Medicaid Expansion (ACA) benefits may be adjusted to be more flexible and Michigan should take advantage of this flexibility for promoting more incentives.</td>
<td>This option will permit the state also to established incentives to access preventive health services and practices.</td>
<td>High</td>
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**ADMINISTRATIVE SERVICES & EFFICIENCIES**

3. Either develop statewide contract for **durable medical equipment**, (may include injectibles, and infusion products) or update the Medicaid fee structure for these products that would result in capturing the savings from the cost structure now present in this area.

   If a single contract were pursued for the Medicaid Fee for Service Program, it would require a statewide bid and contract to take place and followed by Medicaid policy changes. Updating the Medicaid fee structure would be implemented via a Medicaid policy change. Medicaid Health Plans would seek a voluntary agreement process through MAHP.

   **High**

4. Similarly, consider a **statewide contract for transportation services** (non-emergency) to obtain medical services. Both the fee-for-service program and managed care could benefit and there would be consistent provider arrangements for Medicaid beneficiaries.

   Similar to above, Medicaid health plans will seek a voluntary approach to secure volume through a Master Agreement approach administered by the Michigan Association of Health Plans.

   **High**

**PROVIDER REIMBURSEMENT**

5. The MDCH should revise their policy for **short stay outliers or observation stays** and rate established for Medicaid – Their approach is inconsistent with approach used by other carriers—based on standard criteria protocols and recent Medicare Rules.

   Implementation of this initiative would bring Michigan Medicaid into conformance with the Medicare program and eliminate confusion regarding which policy is in place.

   **HIGH**

6. **Hospital Capital Payments**. Hospitals are provided with separate reimbursement for their capital expenses—current policy requires HMOs (and fee-for-service) to pay this on a discharge (total DRG) basis rather than actual use basis — which would be per diem.

   Until October 1, 2004, Medicaid policy permitted flexibility in the payment of capital. Based on the cost impact of the policy returning to the previous policy could result in savings of about $100/admission.

   **Medium to high**

7. Require Hospitals to sign the **Hospital Access Agreement (Medicaid Policy)** in order to receive supplemental funding from Medicaid Health Plans.

   Currently, Medicaid Health Plans rates are inclusive of supplemental funding for Michigan Hospitals. However, not all hospitals have signed the Medicaid Policy assuring access for Medicaid Beneficiaries. Implementation of this recommendation will assure that access.

   **HIGH**
### LEVERAGE OF FEDERAL DOLLARS

8. **Disease management** contracts for fee-for-service beneficiaries. Medicaid HMOs use targeted disease management and case management to address high cost beneficiaries. Medicaid fee-for-service is not able to provide medical management services and patients are left on their own to develop the best program. This proposal would suggest that the state contract with selected HMOs to provide services for the fee-for-service program.

   This option is alternative to those in the Recommendations of our White Paper and would yield fewer saving. Would require state contracting and perhaps a bid program and arrangements could be on a risk-sharing basis.

| Medium |

### COORDINATION WITH OTHER PARTS OF MEDICAID AND OTHER STATE HEALTH PROGRAMS

9. **Expanding Medicaid Managed Care**. About ¾ of the Medicaid expenditures occur in programs not subject to the Medicaid HMO program enrollment and is the area where growth in expenditures will continue (long term care, children’s special health care program, etc.). Efforts need to begin to share best practices from managed care into these areas and review the feasibility of enrollment these Medicaid beneficiaries into a managed care product—that is accompanied by adequate pricing. The experience in Medicaid Managed Care has consistently demonstrated cost-savings, greater access, and program accountability. There is no reason to believe that cannot be achieved in these areas compared to the current fee for service arrangements.

   This is option to those listed in the Recommendations of the White Paper. Assuming even a modest change in policy that promotes the management of care can assist in providing more cost-effective care.

   Changes would obviously involve federal waiver requirements, development of rate structure and enrollment process. However, a template for each of these is in place. Dual Eligible’s (Medicare/Medicaid) may be enrolled in Special Needs Plans that have been certified by CMS

| Medium |

### EXPANSION OF HEALTH CARE COVERAGE

10. **State vendors** — The Administration should consider a requirement that all vendors doing business with State of Michigan provide health insurance for their employees — to address uninsured issues and those who may otherwise qualify for Medicaid.

   While this proposal would not directly impact the Medicaid program — it would assist in assuring that more persons are covered under private insurance and reduce the uninsured population in Michigan.

<p>| Medium |</p>
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<th></th>
<th>Consider moving responsibility for the administration of ABW and County Health Plans to Medicaid Health Plans. This could be done as preliminary to recommendation #13 below.</th>
<th>The populations served by these programs are part of the target population for Medicaid expansion. Several of the Medicaid Health Plans currently provide the administrative services for ABW and County Plans, so a logical extension would be to amend the Medicaid Health Plans Contracts to provide this benefit program.</th>
<th>Medium to High</th>
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<td>MAHP also recommends that statutory revisions be made to regulate the insurance industry in the implementation of guaranteed issue products and other basic benefit coverage options that many employers and individuals currently seek for their employees that will be provided under the State Insurance Exchange. This recommendation will be pursued by MAHP with the House and Senate Health Policy Committees.</td>
<td>This would assure that all carriers approved in Michigan would be subject to similar regulatory requirements and a new competitive environment would be established.</td>
<td>Medium to high</td>
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Several years ago, the Michigan Association of Health Plans adopted a policy that established an “industry” philosophy of care. Within this policy was the following statement that continues to be important in the current discussions regarding the Medicaid program:

“We represent a philosophy of health care that emphasizes active partnerships between patients and their physicians. We believe that comprehensive health care is best provided by networks of health care professionals who are willing to be held accountable for the quality of their services and the satisfaction of their patients. We are committed to high standards of quality and professional ethics, and to the principle that patients come first.”

The Medicaid managed care program has sought to improve outcomes through alignment of financial incentives to stimulate appropriate change in the health care delivery system to:

- hold a single organization accountable for the full range of benefits for a group of beneficiaries;
- provide greater flexibility in the delivery of services compared to fee-for-service requirements;
- improve beneficiary access to needed care;
- provide for the demonstrable improvement in the quality of care delivered; and
- achieve greater cost efficiency and predictability of costs.

The State of Michigan has contracted with HMOs to manage the required comprehensive health care benefits that Medicaid beneficiaries are entitled to receive in order to achieve objectives for ”value purchasing.” These objectives are similar in their intent as the principle developed by MAHP listed above:

- establish standards for network and provider accessibility;
- create reporting and other accountability measures; and
- improve access and quality of customer services, including enrollment services.
ATTACHMENT 3

TABLE OF ADMINISTRATIVE FUNCTIONS PROVIDED BY MEDICAID HMOS

Historically, in the Medicaid fee-for-service program, the state’s major administrative functions were to issue monthly ID cards, enroll providers and to pay claims. In that environment, no effective cost controls existed and state budget expenditures increased steeply from year to year and were unpredictable. To gain cost predictability and control without sacrificing medical benefits, the State engaged health plans to perform functions previously not performed for Medicaid beneficiaries. The underlying administrative infrastructure required of each HMO needs to be understood as critical to their ongoing performance.

Costs associated with these “functions” are not included in those costs labeled “medical costs” or “medical loss ratio” as those measures typically are used to identify how much of the premium dollar received by an HMO is spent on direct health care delivery services. Nevertheless, the cost for the “administrative functions” outlined in this Table are inherently necessary in order to establish and sustain the improved delivery of services for Medicaid beneficiaries consistent with the objectives prescribed by the state and to continue to provide the best value for the State of Michigan.

Notwithstanding additional administrative requirements related to the management of care for Medicaid beneficiaries, the overall average administrative costs incurred by Medicaid health plans continue to decline as a percent of the state premium from 10.3% in CY 2003 to under 8% of total premiums estimated for CY 2009.

**Administrative Functions of Medicaid Health Plans**

<table>
<thead>
<tr>
<th>Category</th>
<th>Feature of Medicaid Health Plans Under the State’s Medicaid Contract and State HMO Requirements</th>
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</table>
| Administration Cost: Beneficiary Services—Member Information | • Member Enrollment Packet (Welcome letter, ID cards, Certificate of Coverage, Provider Directory)  
• Member Handbook at time of enrollment  
• Member Newsletter distributed periodically (no less than 3 times per year)  
• Toll-Free Member Hotline (24/7) to answer questions and resolve problems for members  
• Member Advisory Committees and/or Membership as Consumer member on Governing Body  
• Grievance & Appeal Process including Medicaid Fair Hearing |
<table>
<thead>
<tr>
<th>Administrative Cost: Beneficiary Services—Health Education and Health Promotion</th>
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<tr>
<td>• OFIR external reviews</td>
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<tr>
<td>• Enrollment services functions including special dis-enrollments</td>
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<tr>
<td>• Member Health Education</td>
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<tr>
<td>• Targeted Beneficiary Incentive Programs</td>
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<tr>
<td>• Health Fairs</td>
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<td>• Health Assessment Programs</td>
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<tr>
<td>• Outreach for EPSDT and for services to pregnant women</td>
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<tr>
<th>Administrative Cost: Beneficiary Services—Care Coordination</th>
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<tr>
<td>• Care Coordination, especially with mental health or substance abuse agencies and for Children with special needs</td>
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<tr>
<td>• Case Management</td>
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<tr>
<td>• Disease Management to help members with chronic conditions, such as diabetes or asthma</td>
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<tr>
<td>• Maternal Infant Health Program (MIHP)</td>
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<tr>
<td>• Primary Care Provider—Medical Home</td>
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<tr>
<td>• Local Health Department Coordination, including WIC</td>
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<tr>
<td>• Coordination with Community Mental Health</td>
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<tr>
<td>• Coordination of Transportation</td>
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<tr>
<td>• Referral Management</td>
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<tr>
<td>• For Cause--Disenrollment</td>
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<tr>
<td>• Discharge Planning activities for inpatient services</td>
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<tr>
<td>• Pharmacy management</td>
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<td>• Beneficiary Monitoring Program</td>
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<th>Administrative Cost: Quality of Care Assurance</th>
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<tr>
<td>• Providers who are credentialed every three years</td>
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<tr>
<td>• External Health Plan Accreditation (e.g., NCQA, URAC)</td>
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<tr>
<td>• Individual Site Visits/medical record reviews of Plan Providers</td>
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<tr>
<td>• Focused Clinical Studies and Quality Improvement Plans to improve care identified as less than optimal</td>
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<tr>
<td>• Health Care Standards and Policies, including Access Standards</td>
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<tr>
<td>• Fraud &amp; Abuse policies and activities</td>
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<tr>
<td>• Development and distribution of Clinical Guidelines</td>
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<td>• Profiling and reviewing physician practices for quality measures</td>
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| Administrative Cost: HMO Public Accountability | • Data Reporting to the Department of Community Health  
  o Utilization of Services (Encounter Reporting-Monthly)  
  o Paid Claims (Monthly)  
  o Grievance and Complaints (Semi-Annual)  
  o Data Quality Improvement Reviews (Semi-Annual)  
  o Provider Network (Monthly Updates)  
  o Physician Incentive (Annual)  
  o Litigation Reporting (Annual)  
  • Audited HEDIS Reports (Annual)  
  • HMO Financial Reports (Quarterly and Annual—available on OFIR Web Site)  
  • Customer Satisfaction Surveys (CAHPS), including adolescent CAHPS (available as tool only for Medicaid Products)  
  • Provider Satisfaction Surveys  
  • External Quality Reviews (performed by MDCH)  
  • Administration of annual site visit by OFIR and DCH  
  • External Accreditation from a National Organization |
|---|---|
| Administrative Cost: Provider Services | • Provider Hotline and other provider communications  
  • Provider Manuals, Education, Orientation & Training  
  • Administration of Provider Complaint and Appeals  
  • Electronic Billing Capacity  
  • Coordination of Benefit Activities  
  • Physician and Provider Profiling Reports  
  • Implement all Information Technology Solutions, including ICD-10 |